1983 ANNUAL SUMMARY OF COMMUNICABLE DISEASES

Botulism, infant

Ravalli, 1

Campylobacter - 42

Beaverhead, 2
Fergus, 1
Gallatin, 8
Lewis & Clark, 3
Missoula, 19
Park, 3
Richland, 3
Silver Bow, 2
Yellowstone, 1

Chickenpox - 87

county unknown, 1
Gallatin, 5
Lake, 46
Missoula, 26
Park, 1
Phillips, 2
Yellowstone, 5
military, 1

Coccidioidomycosis - 2

Cascade, 1
Missoula, 1

Colorado Tick Fever - 21

Beaverhead, 3
Blaine, 1
Cascade, 1
Gallatin, 1
Lake, 1
Lincoln, 1
Mineral, 2
Missoula, 4
Musselshell, 1
Park, 1
Rosebud, 1
Yellowstone, 1

Cytomegalo virus - 5

Cascade, 1
Hill, 1
Valley, 1
Yellowstone, 2

Entamoeba histolytica - 2

Missoula, 1
Silver Bow, 1

ECHO virus - 1

Missoula, 1

Guillain-Barre syndrome - 1

Yellowstone, 1

Hepatitis, unspec. - 18

Blaine, 1
Cascade, 2
Gallatin, 3
Lewis & Clark, 1
Yellowstone, 9

Hepatitis, non-A, non-B - 2

Cascade, 1
Missoula, 1

Legionellosis - 9

Cascade, 1
Custer, 2
Fergus, 2
Flathead, 1
Yellowstone, 3

Meningitis, bacterial - 25

Big Horn, 1
Cascade, 2
Gallatin, 6
Hill, 1
Lake, 1
Missoula, 6
Park, 1
Richland, 1
Rosebud, 1
Silver Bow, 3
Yellowstone, 2

Mononucleosis - 10

Gallatin, 5
Lake, 2
Phillips, 1
Ravalli, 1
Yellowstone, 1

Mycoplasma - 38

Beaverhead, 2
Cascade, 1
Chouteau, 1
Custer, 9
Fallon, 1
Fergus, 2
Flathead, 3
Gallatin, 5
Hill, 4
Lewis & Clark, 1
Park, 1
Silver Bow, 4
Yellowstone, 4

Psittacosis - 1

Silver Bow, 1

Reye's syndrome - 1

Jefferson, 1

Rocky Mtn. Spotted Fever - 8

Lake, 1
Lincoln, 1
Mineral, 1
Missoula, 2
Park, 1
Yellowstone, 1
military, 1

Strep throat & scarlet fever

574 cases statewide reported

Syphilis (civilian) - 10

Cascade
  1 Early Latent (<1 year)
  1 Late Latent
Dawson
  2 Late Latent
Hill
  1 Primary
Missoula
  1 Primary
  1 Late Latent
Richland
  1 Secondary
Roosevelt
  1 Secondary
Yellowstone
  1 Primary

Syphilis (military) - 1

  1 Late Latent

Toxic Shock Syndrome - 1

Beaverhead, 1

Toxoplasmosis - 1

Gallatin, 1

Tularemia - 8

Big Horn, 1
Custer, 1
Flathead, 1
Missoula, 1
Yellowstone, 4

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MONTANA MORBIDITY REPORT

Volume: 8:3

Month of: March 1984 Extra Issue - Annual Summary 1983

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v.8#3
March 1984

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, Montana 59620. Distributed FREE to physicians, public health nurses, sanitarians, hospital administrators.

		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels															
	Phillips			2												2
	Roosevelt															14
	Sheridan															2
	Valley										6					1
DISTRICT 2	Dawson															1
	Garfield															
	McCone															
	Prairie															
	Richland															1
	Wibaux															1
DISTRICT 3	Carter															
	Custer														1	2
	Fallon															
	Powder River															
	Rosebud															7
	Treasure															
DIST. 4	Blaine														1	3
	Hill														1	8
	Liberty															1
DISTRICT 5	Cascade			1							1		1	1		9
	Chouteau															
	Glacier											1				9
	Pondera															
	Teton															
	Toole															1
DISTRICT 6	Fergus															1
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn												1		2	2
	Carbon				1											
	Stillwater															
	Sweet Grass															
	Yellowstone				1	1							1	1		40
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			1												5
DIST. 9	Gallatin			4												4
	Meagher															
	Park															
DISTRICT 10	Flathead															2
	Lake															2
	Lincoln														1	
	Sanders															
DIST. 11	Mineral															2
	Missoula			9											2	10
	Ravalli															
DISTRICT 12	Beaverhead			1												2
	Deer Lodge															
	Granite															
	Madison			1												
	Powell															
	Silver Bow															
MONTHLY TOTAL	Dec 1983	0	0	19	2	1	1	0	0	0	7	1	3	2	8	132
	1982	0	0	5	0	0	0	0	2	0	12	1	4	0	3	112
	1981	0	0	6	0	0	0	2	0	0	2	0	3	0	8	142
TOTAL TO DATE	1983	8	2	242	27	20	5	1	9	2	115	7	162	19	50	1122
	1982	4	0	108	27	7	0	10	9	1	94	4	110	39	44	1351
	1981	19	2	137	80	22	1	11	13	7	115	4	107	22	43	1535

DELAYED REPORTS:

Late latent syphilis - Dawson 1; Missoula 1

OTHER DISEASES Campylobacter - Missoula, 4; Beaverhead, 1

Tularemia - Yellowstone, 1
Pediculosis - Gallatin, 2; Lake 2; Cascade, 1
Cytomegalovirus - Yellowstone 1
Mycoplasma - Flathead 1
Legionella - Silver Bow 1

PREVENTING TRANSMISSION OF HEPATITIS A: The Importance of Day Care Centers

Of all the factors involved in the spread of hepatitis A, none currently is more critical than the gathering of susceptible infants and children in day care centers. Spread of infection is possible in any child-care setting, but it is especially troublesome in those centers that care for diapered children. The behavior of 1-3 year old children is such that child-care centers, where they congregate regularly, experience outbreaks of enteric diseases, including giardiasis, common diarrhea, bacillary dysentery, and hepatitis A. Poor sanitation and hygiene are often major contributing factors in hepatitis A outbreaks traced to day care centers. Hepatitis A transmission occurs much less frequently in centers where child-to-child, as well as child-to-staff-to-child, fecal contamination is reduced to a minimum.

In preventing hepatitis there is only one fundamental "tool": That is the regular enforcement of sound sanitary and hygienic practices to protect susceptible individuals from contaminated fecal matter. Thorough handwashing (before handling or preparing food, after using the restroom, and after each diaper change) is the single most important measure in preventing or stopping the transmission of hepatitis A and other enteric illnesses. Not only must staff members be constantly reminded to maintain personal hygiene, they should also personally wash or supervise the washing of children's hands.

Recognizing a Hepatitis Outbreak

Sporatic, "isolated" cases of hepatitis will occur in any population. The association of these cases with other cases is seldom readily perceived, but infection usually results from unrecognized direct contact with infected persons, or, infrequently, from contaminated food or water.

Sanitary inspection and evaluation of water supplies should be postponed until the usual mode of transmission, i.e., person-to-person spread, is thoroughly investigated. In every instance, it is the responsibility of the attending physician and public health workers to search for the chain of transmission so as to prevent additional cases.

The occurrence of cases of hepatitis A in children, teenagers, or young adults, who seem to have no direct exposure to one another, should raise the question of day care center involvement. It should be immediately ascertained whether or not persons known to have hepatitis have family members who attend the same day care center. If so, there is a good chance that transmission is occurring at the child-care center.

Infants and young children experience few, if any signs or symptoms, when infected with hepatitis A virus. A typical sequence is as follows:

> A "sporadic" case of hepatitis A occurs in a teenager or young adult. By close personal contact or via poor sanitation in the home, this infection passes to an infant or young child who attends a day care center. About a month later, this child, who is feeling well or perhaps having a little diarrhea, directly contaminates other children in the center or has diapers changed by a busy or untrained day care worker who fails to wash his or her hands. Other children are subsequently infected by the worker who puts her fingers in children's mouths or contaminates food during preparation. The newly infected children develop clinical or subclinical illness after the passing of another incubation period. The severity of illness in these children may range from no symptoms to a mild, diarrheal-type illness to a more severe, flu-like illness. These children, in turn, infect their parents, siblings, and other susceptible members of their households who then develop acute symptomatic cases of hepatitis, after yet another incubation period. Because this sequence takes place over several months, any association with the day care center often goes unrecognized.

Stopping the Outbreak

When a cluster of hepatitis A cases is recognized as being related to a day care center, the following actions should be taken:

1. The day care center operator should be notified and hygienic practices instituted with guidance from the local health department. Good personal hygiene is essential, particularly handwashing before meals and after toileting or diaper changes. Only disposable diapers, properly disposed of in plastic garbage bags, should be used during the outbreak. Surfaces upon which diapers are changed should be scrubbed after each use with disinfectant solution (¼ cup of household bleach per gallon of tap water prepared daily and dispensed in spray bottles).
2. The day care center operator should notify all parents or guardians that:
   a) the children may have been exposed to hepatitis,
   b) children and other family members should be observed closely for signs of illness with the understanding that subclinical or asymptomatic cases do occur, and
   c) all exposed persons need to be protected with hygienic measures and IG as medically indicated.
3. Centers should remain open. Parents should be discouraged from transferring even apparently healthy children to other centers thereby spreading infection to new centers. New admissions to the center should be stopped until the improved hygienic discipline has been introduced. It may be necessary to require new admissions to receive IG for a period of time.
4. All staff and children in the day care center should be protected with immune globulin unless known to be immune because of prior infection. Conscientious follow-up by health workers often is necessary to ensure that notification and advice reaches all those at risk of exposure.
5. All persons potentially exposed to hepatitis should seek appropriate medical care. IG in proper dosage should be administered within 10-14 days following close personal contact with a known case of hepatitis A.
6. Public health workers should conduct active surveillance of all exposed families to identify new cases and to protect persons imtimately exposed to known or newly developing cases of hepatitis A.
7. Exposed foodhandlers should be kept under strict surveillance and instructed in the safe handling of food to avoid possible contamination.

Effective action to interrupt the transmission of hepatitis A is dependent upon the timely reporting of cases or suspected cases to the proper health authorities. A day care center director may be the first to recognize that "something is going around", and thus, contact the local health department for assistance and advice. A rapid response by attending physicians and public health workers is essential to assist the day care center in establishing hygienic and sanitary control measures. Exposed persons should be protected with immune globulin within as few days as possible after exposure takes place. This means rapid communication and expeditious scheduling of visits to physicians' offices (or public health clinics) for administration of immune globulin. Each day of delay can mean additional cases.*

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* This report was prepared by Charles R. Webb, Jr., M.D., Director, Public Health Region 6, Texas Department of Health.

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Volume: 7:12 Month of: November 1983

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Nov.1983

		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels															
	Phillips								1							
	Roosevelt			1	1											7
	Sheridan															1
	Valley										2					1
DISTRICT 2	Dawson															
	Garfield															
	McCone										1					
	Prairie															
	Richland															1
	Wibaux										1					
DISTRICT 3	Carter															
	Custer															
	Fallon															8
	Powder River															
	Rosebud															8
	Treasure															
DIST. 4	Blaine															2
	Hill			1						1						8
	Liberty															
DISTRICT 5	Cascade			5												5
	Chouteau			1									1			1
	Glacier															11
	Pondera															
	Teton															
	Toole										2					
DISTRICT 6	Fergus															4
	Golden Valley															1
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn					1								1		1
	Carbon			2												
	Stillwater															
	Sweet Grass															
	Yellowstone				1		1*						1			26
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			1												11
DIST. 9	Gallatin								1							5
	Meagher															
	Park															
DISTRICT 10	Flathead															2
	Lake				1											3
	Lincoln															3
	Sanders															
DIST. 11	Mineral															2
	Missoula			8												12
	Ravalli															1
DISTRICT 12	Beaverhead															2
	Deer Lodge															
	Granite															
	Madison															
	Powell															5
	Silver Bow												1			1
MONTHLY TOTAL	1983	0	0	19	3	1	1*	0	2	1	6	0	3	1	0	132
	1982	0	0	7	1	1	0	1	1	0	0	0	4	1	2	124
	1981	0	0	12	1	2	0	1	1	0	6	0	2	1	1	121
TOTAL TO DATE	1983	8	2	223	25	19	4*	1	9	2	108	6	159	17	42	990
	1982	4	0	103	27	7	0	10	7	1	82	3	106	39	41	1239
	1981	19	2	131	80	22	1	9	13	7	113	4	104	22	35	1393

DELAYED REPORTS: *Yellowstone County measles case is an out-of-state importation.

Brucellosis: Missoula, 1
Rocky Mtn Spotted Fever: Lincoln, 1; Park, 1

Late latent syphilis: Dawson, 1; Yellowstone, 1

OTHER DISEASES: Mycoplasma: Park, 1
Mononucleosis: Gallatin, 5; Lake, 2; Phillips, 1; Ravalli, 1
Campylobacter: Gallatin, 1; Park, 1; Richland, 1
Reye's Syndrome: Jefferson, 1
Pediculosis: Lake, 9; Phillips, 2
Scabies: Big Horn, 9; Cascade, 5; Lake, 1; Yellowstone, 1

INFECTIOUSNESS OF COLD SORES

A high percentage of individuals suffer from cold sores or fever blisters caused by the herpes virus. While this disease may be considered a nuisance in adults, it can be quite dangerous in newborns. For that reason, it is important to protect newborns from exposure to this virus. An active form of herpes on the lip may be present in one percent of all nusery personnel in hospitals during any given week. Recent studies show that this virus can be spread without direct contact with the lesion.

Doctors at the University of Virginia in Charlottesville studied the spread of the virus by hand contact and from various environmental surfaces and from sneezing and coughing.[1] In 15 acute episodes in the 11 volunteers, they cultured the virus from the saliva in 78 percent. The virus was also cultured from the hands in 6 of 9 participants (67 percent). The hands were almost as contagious as the saliva, and must be almost equally as important as kissing in the spread of the disease. Sneeze plates yielded positive cultures in only 15 percent and nothing was cultured from cough plates. The studies showed that the herpes virus survived at least an hour on environmental surfaces. The maximum period of survival was approximately 4 hours.

These observations strengthen the American Academy of Pediatric's recommendation that oral lesions should be covered and hand washing techniques strictly observed by infected adults caring for newborns. Masks should be worn, clothing changed, and contaminated surfaces cleaned with alcohol or benzalkonium chloride.

Adults with cold sores should follow similar guidelines to avoid infecting friends and loved ones. Evidence is becoming available that the disease is spread much the same way as the common cold.[2]

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1. Pediatrics 70:1982, 547.
2. The Health Letter 22, Number 4. August 26, 1983.

NEW TELEPHONE NUMBERS - We realize that many of you have had difficulty reaching state offices in the last few weeks. We apologize for the inconvenience due to the changeover of the state phone system, with all new numbers. Listed below are the new numbers for Communicable Disease Control:

Dave Bean, VD Control/TB Control -- 444-3621

Valinda Holmes, VD Control -------- 444-3949

Judy Gedrose, TB Control/Communicable Diseases Control/Rabies Unit 444-3696

Maxine Ferguson, Nursing Bureau --- 444-4489

Rabies Unit (after hours answering) 444-4740

Rick Nelson, Childhood Immunization/VD Control/Communicable Diseases ---------- 444-3629

Dick Paulsen, Childhood Immunization/VD Control ---------- 444-3624

Beth Smith, Childhood Immunization ---------- 444-3986

NOTE: We have had a number of reusable ice packs sent back to the department with the fluid emptied from them. PLEASE DO NOT EMPTY THE ICE PACKS. The ice packs are filled with a special fluid and should remain intact!

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MONTANA MORBIDITY REPORT

Volume: 7:11 Month of: October 1983

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OCTOBER 1983

		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels										1					
	Phillips															
	Roosevelt															17
	Sheridan										1					
	Valley			1							4		1			1
DISTRICT 2	Dawson															
	Garfield															
	McCone										1					
	Prairie										1					
	Richland															
	Wibaux															
DISTRICT 3	Carter															
	Custer															
	Fallon										1					
	Powder River															
	Rosebud															5
	Treasure															
DIST. 4	Blaine															1
	Hill															8
	Liberty															
DISTRICT 5	Cascade			2									2			3
	Chouteau															1
	Glacier															7
	Pondera															
	Teton															
	Toole															
DISTRICT 6	Fergus															2
	Golden Valley															
	Judith Basin															
	Musselshell															1
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn	1									1		2			2
	Carbon															1
	Stillwater															1
	Sweet Grass			1												
	Yellowstone	1			1		2*				1					14
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			1					2				1			11
DIST. 9	Gallatin			3					1				1			7
	Meagher															
	Park															1
DISTRICT 10	Flathead															5
	Lake															
	Lincoln															1
	Sanders															
DIST. 11	Mineral															
	Missoula			8			1*						2			3
	Ravalli															
DISTRICT 12	Beaverhead												1			1
	Deer Lodge															2
	Granite															
	Madison															
	Powell															
	Silver Bow	1														3
MONTHLY TOTAL	19 83	3	0	16	1	0	3*	0	3	0	11	0	10	0	0	98
	19 82	1	0	10	1	0	0	2	1	0	0	0	18	7	3	136
	19 81	1	0	11	2	0	0	0	1	0	8	0	2	2	2	142
TOTAL TO DATE	19 83	8	2	204	22	18	3*	1	7	1	102	6	156	16	42	858
	19 82	4	0	96	26	6	0	2	6	1	82	3	102	38	39	1115
	19 81	19	2	119	79	20	1	8	12	7	107	4	102	21	34	1272

DELAYED REPORTS: *Measles/Rubeola above* - all 3 cases are out-of-state importations

OTHER DISEASES: Cytomegalovirus: Valley 1, Hill 1;
Pediculosis: Gallatin 3;
Scarlet fever: Missoula 1.

TUBERCULOSIS SCREENING IN HEALTH CARE FACILITIES OF EMPLOYEES AND PATIENTS

Recently many inquiries have been presented to Montana Department of Health and Environmental Sciences about follow-up of persons with positive tuberculosis antigen skin tests. An article in the FDA Bulletin (quoted in this publication August 1983) regarding unnecessary chest X-rays, may be one of the stimulus for the inquiries.

For several years, the Administrative Rules of Montana related to health care facilites licensing have required employees and long-term patients in health care facilites to have their tuberculosis status determined on inital employment or residence, respectively, and annually thereafter. The current rule is printed below:

16.32.307 MINIMUM STANDARDS FOR ALL HEALTH CARE FACILITIES -- COMMUNICABLE DISEASE CONTROL (1) Each employee of a health care facility shall provide documentation by a physician that he is free from communicable tuberculosis prior to the time of employment and annually thereafter.

(2) At time of admission and annually thereafter, a patient admitted to or residing in a long-term care facility shall provide documentation by a physician that he is free from communicable tuberculosis. (History: 50-5-103, 50-5-404 MCA; IMP, Sec. 50-5-103, 50-5-204, 50-5-404 MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80.)

Administrative Rules of Montana
page 16-1480,7/1/80.

There is a need for yearly checking of the TB status of these two groups. Hospital employees are always at risk of being exposed to an undiagnosed tuberculosis case. Older persons are in the age group with the most new disease cases due to past infection.1

The rule was written to give facilities some flexibility in developing their procedures for providing the yearly documentation that employees and residents are tuberculosis disease free. It also acknowledges the need for each person requiring testing to be evaluated individually; i.e. everyone with a positive skin test may not need a yearly chest X-ray. Hospital employees may need a different protocol for screening than do residents of long-term care facilities. Some suggestions are offered for a policy health care facilites may wish to adopt for meeting the yearly requirement of documentation that all employees are free of TB.

A. A tuberculin skin test shall be conducted on employment in the manner outlined below:
   1. an intra-dermal injection of 5 t.u. of purified-protein derivative upon initial employment;
   2. record the size of any palpable induration, in millimeters, as measured in no less than 72 hours following injection.
      a. A reaction of 5-10 m.m. or larger (positive) requires follow-up to determine whether or not the person tested has active tuberculosis disease.
      b. A negative reaction is one in which induration is not present or less than 5 m.m.

B. If the employee's tuberculin test is negative, the employee needs to be retested on a yearly basis. If the employee has frequent or close exposure to a person with communicable tuberculosis, retesting should be done as soon as possible after exposure is known and three (3) months after the date contact was broken.

C. If the employee's initial test is positive, or the employee has ever in the past had a positive tuberculin skin test with purified-protein derivative, and not received adequate chemoprophylaxis, he must be evaluated by a physician to determine if any of the following situations exist; since they increase the risk of t.b. infection becoming active disease:
   1. X-rays indicative of tuberculosis infection;
   2. history of exposure to a communicable case of tuberculosis within the previous two years;
   3. negative skin test within the last two years;
   4. severe or poorly controlled diabetes;
   5. immunologic deficiencies;
   6. immunosuppressive therapy;
   7. chronic obstructive pulmonary disease;
   8. gastrectomy;

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Volume: 7:10 Month of: Extra issue

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9. renal transplantation; and/or
10. ileal bypass surgery for obesity.2

D. If any of the conditions listed are present, the tuberculin-positive employee must be counselled that he is at relatively high risk of developing tuberculosis disease and that he should complete one year of chemoprophylaxis, if he has not already done so, unless medically contraindicated. If the employee has current tuberculosis disease, he must complete a course of chemotherapy with at least two anti-tuberculosis drugs as prescribed by a physician and not less than 9 months of uninterrupted therapy.
   1. An employee with any of the above listed conditions who completes one year of isoniazid chemoprophylaxis or other adequate anti-tuberculosis chemotherapy will not be required to take further chest X-rays unless he is exposed to communicable tuberculosis or becomes symptomatic. An employee in this category must be re-evaluated annually by a physician.
   2. An employee with a positve tuberculin skin test and any of the above listed conditions who has not completed chemoprophylaxis must have a chest X-ray and physician consultation annually.3

E. An employee with a positive tuberculin skin test who hasn't taken chemoprophylaxis and who does not have any of the above conditions must have a chest x-ray annually for three years. If all three are negative, the annual physician examination need not include a chest X-ray.

F. If an employee of a health care facility has been exposed to a case of communicable tuberculosis, then a contact investigation must be conducted by the local health officer or another appropriate health professional.

TUBERCULOSIS SCREENING FOR PATIENTS IN LONG-TERM CARE FACILITIES

As stated above, separate recommendations may be in order for long-term care patients. The following are based on Centers for Disease Control recommendations:

> "---screening for tuberculosis in nursing homes should consist of both a chest X-ray and a two-step tuberculin skin test on admission. Patients whose tests are positive and/or whose chest x-rays are consistent with tuberculosis(infection) should be throughly evaluated to exclude current disease, INH preventive therapy should be given according to published recommendations...
> Patients with positive skin tests and negative chest X-rays who have not completed a course of preventive therapy should be carefully monitored for symptoms suggesting tuberculosis; periodic chest X-rays are not recommended..." 4

Each patient of a long-term care facility needs to have his/her TB status determined annually. Patients with negative skin tests should continue receiving skin tests. Patients with known positives need to be evaluated by a physician annually.

Employees of health care facilities should consider all patients seen for an extended period of time as patients requiring annual documentation of tuberculosis status. Some of these groups are at a higher risk of having t.b. infection than the general public. These groups include at least the following:

1. patients of home health agencies;
2. hospice patients;
3. kidney treatment center patients;
4. mental health centers;
5. public health centers continuing clients;
6. rehabilitation centers; and
7. adult-day care settings.

COMMENTS

The incidence of tuberculosis in Montana is approximatley one-half of that of the entire U.S. But our actual number of new cases has increased annually for two years now after a steady ten year decline. Continued surveillance of high risk groups and the maintenance of a high index of supicion for cases is critical. Therefore each health facility employee and patient of a long-term care facility must have his/her tuberculosis status evaluated annually.

The Tuberculosis Control Program exists to assist you. If you have questions or concerns, please don't hesitate to call: Judith Gedrose or Dave Bean at 444-4740 or 444-3696 or 444-3621.

1. Stead, William. "The Pathogenesis of Pulmonary Tuberculosis Among Older Persons", American Review of Respiratory Diseases (Volume 91, Number 6, pages 811-822 and 901-906).
2. American Thoracic Society. "Screening for Pulmonary Tuberculosis in Institutions", American Review of Respiratory Disease (Volume 115, 1977).
3. Faver, L. "Chemoprophylaxis Against Tuberculosis", Clinics in Chest Medicine (Volume 1, Number 2, May 1980).
4. "Tuberculosis in a Nursing Home", Oklahoma Morbidity and Mortality Weekly Report (Sept. 26, 1980).

COMMUNICABLE DISEASES CONTROL - Who's Who and Who Does What?

While the Administrative Rules of Montana (1980) and the Montana Handbook of Reportable Diseases (1983) offer guidelines for communicable disease control, it is sometimes necessary to clarify the role of both the state and local health departments in these activities. With the reorganization of the Montana State Department of Health & Environmental Sciences completed as of July 1, 1983, it seems timely to do such a reclarification.

Under the medical direction of Doctors Drynan, Pratt, and Espelin; Judith Gedrose, R.N., M.N., has assumed the role of state epidemiologist. Questions regarding diseases other than sexually transmissible (STD) and immunizable diseases (ID) should be directed to her. She will take the responsibility for involving other Montana State Department of Health & Environmental Sciences staff as appropriate.

Rick Nelson remains the program manager for the STD and ID programs; concerns related with these areas should be directed to him.

Clerical persons will always have the name of a MSDHES staff member to which they should direct communicable disease calls if Gedrose is not available. This person will usually be Nelson.

Bruce Desonia, Steve Linder, and Dick Paulsen (field health officers) will continue their roles in assisting Gedrose and Nelson with communicable disease control. As in the past, a majority of their time will continue to be directed toward STD and ID activities.

Dave Bean will continue contributing most of his time to STD services but has also assumed an active role in Tuberculosis control. Desonia, Linder, Paulsen, and Bean will be utilized for communicable disease control other than STD and ID on a consultative and as needed basis.

MEASLES IS BACK IN MONTANA

During the first week of October, 3 cases of measles have been identified in Montana which include two pre-schoolers in Billings and one adult female in Missoula. All three were due to exposure to a 13-year-old boy at a wedding in Spokane, Washington in late September. Several cases reported in other states have occurred from the same exposure. The greatest concern for sustained transmission is the number of unvaccinated susceptibles in Montana. Most of these susceptibles are either pre-schoolers or young adults past high school age. If this outbreak in Montana is to be confined to first or several generations cases, emphasis must be placed on parents to assure that their children are immunized. If anyone has a suspicion that a person may have measles, contact your local health department and the Immunization Program in Helena at 449-4740 as soon as possible.

Last chance - Do it now!

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MONTANA MORBIDITY REPORT

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Sept. 1983

		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRIC 1	Daniels															
	Phillips															
	Roosevelt															12
	Sheridan															
	Valley		1										1			
DISTRICT 2	Dawson															
	Garfield															
	McCone															
	Prairie															
	Richland												1			1
	Wibaux															
DISTRICT 3	Carter															
	Custer															1
	Fallon															
	Powder River															
	Rosebud										1					8
	Treasure															
DIST. 4	Blaine												1			4
	Hill		1	2												6
	Liberty															
DISTRICT 5	Cascade								2		2		1			13
	Chouteau															
	Glacier															2
	Pondera			1											1	
	Teton										1					
	Toole															
DISTRICT 6	Fergus	1														1
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn												1	2		4
	Carbon			2												
	Stillwater															
	Sweet Grass															
	Yellowstone			6	1			1					3		1	15
DIST. 8	Broadwater															
	Jefferson														1	
	Lewis & Clark			2		1					2	1			1	5
DIST. 9	Gallatin			6	1							1	3		1	3
	Meagher															
	Park			1												2
DISTRICT 10	Flathead												1			3
	Lake												1	1		
	Lincoln															1
	Sanders															1
DIST. 11	Mineral															
	Missoula												8		1	8
	Ravalli			4	1								1			1
DISTRICT 12	Beaverhead			6												
	Deer Lodge												1			
	Granite															
	Madison															
	Powell			1												3
	Silver Bow	1											4		1	1
MONTHLY TOTAL	19 83	2	2	31	3	1	0	1	2	0	5	2	27	3	7	95
	19 82	0	0	13	2	2	0	0	0	0	17	0	10	5	7	106
	19 81	2	1	5	5	1	0	1	0	0	10	0	1	2	1	147
TOTAL TO DATE	19 83	5	2	188	21	18	0	1	4	1	91	6	146	16	47	760
	19 82	3	0	86	25	6	0	7	5	1	82	3	84	31	36	979
	19 81	16	2	94	71	18	0	7	10	7	92	4	95	19	32	1045

DELAYED REPORTS:

OTHER DISEASES: Campylobacter: Missoula 4, Park 1, Gallatin 2; Rocky Mtn Spotted Fever: Missoula 1; Legionellosis: Custer 1

Be Aware of the Change in the Law and Rules related to Premarital Serologies

As of October 1, 1983, premarital serologies for syphilis are no longer required. The serological testing for rubella will continue to be required for female marriage license applicants.

Montana Code Annotated section 40-1-203 through 40-1-208 has been amended to allow this change. Administrative Rules of Montana beginning on page 16-1865 are being revised to correspond to the changes in the statute.

As the statement of intent for Senate Bill 180 states, "--the test [for rubella] is of value only to women capable of bearing children;there is no purpose in requiring the test of women incapable of doing so. Therefore, the rules would [will] define those categories of women whose medical status precludes them--".

The new rules will be available October 1, 1983 from Montana State Department of Health & Environmental Sciences. They specify the type of certificate form required and procedures for completion of it, as well as how exemptions from the requirement for rubella serologies are to be handled.

A Significant Tuberculin Skin Test? - Isoniazid for TB Prevention

The tuberculin skin test is a reliable method of determining whether or not a person is infected with Mycobacterium tuberculosis (M. tb.). Because of the nature of M. tb. and the body's response to it, many infected persons are not diseased. A negative chest X-ray after a significant skin test indicates a person is in this "infected without disease" category.

Isoniazid (INH) at the rate of 10 mg/kg/day can prevent those infected persons from breaking down and becoming cases of tuberculin disease in the future. Centers for Disease Control - American Thoracic Society (CDC-ATS) guidelines recommend that everyone with a significant skin test be considered as a candidate for INH prevention therapy. The person taking INH should be monitored on a monthly basis for the following reasons: (1) To detect any signs or symptoms of liver malfunction--the drug should be discontinued if clinical symptoms suggest liver changes, and (2) to reinforce the need for a year of daily medication in an essentially well person.

Montana State Department of Health & Environmental Sciences supports the recommendations of CDC-ATS. INH is available free-of-charge to all skin test reactors, whether or not they are contacts to cases. A prescription for INH can be sent from any public or private physician to: TB Control, Health Services and Medical Facilities Division, Cogswell Bldg., Helena, MT 59620.

Chest X-ray Screening Statements

Five chest X-ray referral criteria statements have been developed and unanimously endorsed by a panel of physicians convened as part of a cooperative effort with FDA's National Center for Devices and Radiological Health (NCDRH). *

1. All mandated routine screening examinations of unselected populations should be discontinued, unless a significant yield can be shown.
2. All routine prenatal chest X-ray screening examinations for the detection of unsuspected disease should be discontinued.
3. Routine chest radiographs should not be required solely because of hospital admission.
4. Mandated chest X-ray examinations for employment, repeated chest X-ray examinations upon long-term facility admission, repeated chest X-ray examinations of tuberculosis reactors, repeated chest X-ray examinations of asymptomatic tuberculosis patients who have completed therapy, and routine periodic chest X-ray examinations during tuberculosis treatment have all been shown to be of insufficient clinical value to justify continued use.
5. Routine nonselective preplacement chest X-ray examinations and periodic examinations unrelated to job exposure should be discontinued.

* It should be emphasized that these statements do not preclude chest X-ray exams based upon individual history, physical examinations, or specific diagnostic testing, or in selected populations shown to have significant yields of previously undiagnosed disease.

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Aug. 1983

		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels															
	Phillips															1
	Roosevelt			1										1		12
	Sheridan															
	Valley										1					1
DISTRICT 2	Dawson															
	Garfield															
	McCone										1					
	Prairie															
	Richland															
	Wibaux															
DISTRICT 3	Carter										1					
	Custer															1
	Fallon															
	Powder River															
	Rosebud			1							1					9
	Treasure															
DIST. 4	Blaine															2
	Hill	1									1					11
	Liberty															
DISTRICT 5	Cascade	1			1	2					1		7	4		12
	Chouteau															
	Glacier															7
	Pondera			1												
	Teton															
	Toole															
DISTRICT 6	Fergus															
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															1
DISTRICT 7	Big Horn															5
	Carbon															
	Stillwater															
	Sweet Grass															
	Yellowstone					2							2			14
DIST. 8	Broadwater															
	Jefferson										1					
	Lewis & Clark			1							2		1			4
DIST. 9	Gallatin															
	Meagher															
	Park															
DISTRICT 10	Flathead												3			4
	Lake															1
	Lincoln															6
	Sanders															1
DIST. 11	Mineral			1												
	Missoula			1	1	3							6	1		10
	Ravalli			3	1	1										1
DISTRICT 12	Beaverhead															1
	Deer Lodge										1		9			
	Granite															
	Madison										1					
	Powell															
	Silver Bow												1			1
MONTHLY TOTAL	1983 Aug	2	0	9	3	8	0	0	0	0	11	0	29	6	0	105
	1982 Aug	1	0	7	2	0	0	0	0	0	13	0	12	6	3	112
	1981 Aug	4	1	9	14	2	0	1	2	0	12	0	13	1	5	117
TOTAL TO DATE	1983	2	3	157	18	17	0	0	2	1	86	4	119	13	40	665
	1982	3	0	73	23	4	0	7	5	1	65	3	74	26	29	873
	1981	14	1	87	71	18	0	7	10	7	87	4	93	19	27	977

DELAYED REPORTS

OTHER DISEASES

Campylobacter - Park 1, Silver Bow 1, L&C 2, Richland 2, Missoula 4

RMSF - Missoula 1, Yellowstone 1, Lincoln 1, Mineral 1

Tularemia - Big Horn 1, Yellowstone 1, Missoula 1.

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INFLUENZA VACCINE RECOMMENDATIONS

The Immunization Practices Advisory Committee (ACIP) has issued its recommendations for use of influenza vaccine to protect high risk individuals during the 1983-84 influenza season. (1)

The only new element in this year's recommendations is a change in the vaccine formulation. One 0.5 ml dose of this season's vaccine will contain 15 ug of hemagglutinen antigen from each of the A/Brazil/78 (H1N1), A/Philippines/82 (H3N2), and B/Singapore/79 viruses. The A/Philippines/82 (H3N2) virus has been substituted for the A/Bangkok/79 (H3N2) virus which had been used in the vaccine for the past three seasons. This substitution was made because the A/Philippines/82 virus has accounted for an increasing proportion of the H3N2 strains identified in Asia since mid-1982 and was identified last winter in Europe and North America.

The list of persons for whom annual vaccination is strongly recommended remains unchanged:

1. For all older persons, particularly those over 65 years, because the risk of death during influenza outbreaks generally increases with age.
2. For all persons (children and adults) who are at increased risk of adverse consequences from infections of the lower respiratory tract because of a pre-existing medical condition.

Conditions predisposing to such increased risk include:

a) Acquired or congenital heart disease with actual or potential alterations in circulatory dynamics (e.g., mitral stenosis, congestive heart failure, or pulmonary-vascular overload).
b) Any chronic disorder or condition that compromises pulmonary function (e.g., chronic obstructive pulmonary disease, bronchiectasis, heavy smoking, tuberculosis, severe asthma, cystic fibrosis, neuromuscular and orthopedic disorders with impaired ventilation, broncho-pulmonary dysplasia following the neonatal respiratory distress syndrome).
c) Chronic renal disease with azotemia or nephrotic syndrome.
d) Diabetes mellitus or other metabolic diseases.
e) Severe chronic anemia, such as sickle cell disease.
f) Conditions that compromise the immune mechanism, including certain malignancies and immunosuppressive therapy.

REFERENCES

1. Centers for Disease Control: Recommendations of the Immunization Practices Advisory Committee (ACIP): Influenza Vaccines, 1983-84. MMWR July 8, 1983;32:333-337.
Reprinted from Oregon Communicable Disease Summary, Vol. 23. No. 15.

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July 1983

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INH PREVENTIVE THERAPY FOR TUBERCULOSIS--Is twelve months necessary? (1)

We present the American Thoracic Society's Guidelines for identifying those who should receive INH preventive therapy for tuberculosis (see Table 1) and a further discussion on this issue.

TABLE 1: ATS Guidelines to Define Who Should Receive INH Preventive Therapy include:

1) Household contacts and other close associates of persons with recently diagnosed tuberculosis. This includes all such contacts with positive skin tests. It also includes young children with negative skin tests until they are shown to remain skin test negative three months after last exposure.
2) Persons with positive skin tests who have x-ray findings of previous tuberculous disease but no evidence of current disease and no history of adequate chemotherapy.
3) Newly infected persons (defined as a person whose Mantoux method skin test reaction has increased by at least 6mm from <10mm induration to >10 mm in the last two years).
4) Positive tuberculin skin test reactors with the following special risk factors:
   (a) Prolonged therapy with corticosteroids
   (b) Immunosuppressive therapy
   (c) Leukemia or Hodgkin's Disease
   (d) Diabetes mellitus
   (e) Silicosis
   (f) Post-gastrectomy status
5) Other positive tuberculin skin test reactors under age 35.

NOTE: Groups 1 through 4 apply to persons over age 35 as well as persons under that age.

When faced with the difficulties of persuading well patients to take 300 mg of INH each day for twelve months, health care providers often ask whether the full 12 months is necessary to achieve any preventative benefit. They ask how much preventive benefit has been achieved for the patient who takes INH for only three months or six months.

A recent study has provided some information regarding the effectiveness of different durations of the INH prophylaxis in one of the patient groups for whom prophylaxis is recommended. (2) The specific risk group was that of persons with positive skin tests, x-ray findings of previous tuberculous disease and no history of adequate chemotherapy.

The study was conducted by the International Union Against Tuberculosis in seven European countries. Over 27,000 patients with positive skin tests, negative sputum cultures, and "well-delineated radiographic lesions of probable tuberculous origin...which had been stable during the year prior to entry", were enrolled. They were randomly assigned to receive INH or placebo for 12, 24, or 52 weeks of treatment. The participants were given a new supply of pills each month. The patient who took at least 24 pills each month was considered compliant. Participants were examined each year for five years to identify whether tuberculosis disease developed.

When compared to the participants who took placebo, those assigned to 12 weeks of INH benefited by a 21% reduction in the incidence of tuberculosis during the five-year follow-up period. Those assigned to 24 weeks of INH had a 65% reduction as compared to the placebo group, while the 52 week group had a 75% reduction.

Of special interest is the comparison of those who were "compliant" with the regimen to which they were assigned and who completed that regimen. The results shown in Table 2 suggest that for those who reliably took their INH, six months of preventive therapy is much more effective than three months, and twelve months is much better than six.

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RABIES PREVENTION

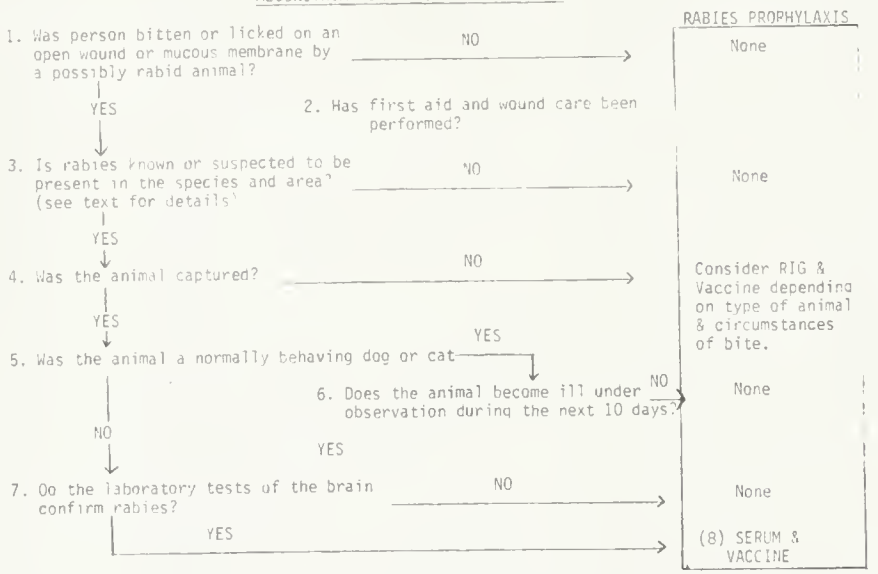
Although rabies rarely affects humans in the U.S., animal bites are extremely common. It is estimated that over one million people in this country are bitten by animals each year. Approximately 30,000 of these persons receive post-exposure prophylaxis. Post-exposure rabies prophylaxis includes both human diploid cell rabies vaccine (HDCV) and human rabies immune globulin (RIG).

GENERAL CONSIDERATION FOR RABIES PROPHYLAXIS

1. Rabies occurs in many wild animals, bats, and domestic animals, such as dogs, cats, and cattle, but rarely in rodents.
2. A dog or cat that remains healthy for 10 days after a bite does not have rabies, and prophylaxis for a person bitten by that animal is not indicated.
3. A negative fluorescent antibody (FA) examination of an animal brain in the animal lab at Montana State University is reliable evidence that the animal does not have rabies.
4. Saliva of a rabid animal on an open wound (usually a bite) or mucous membrane consitutes exposure to rabies.
5. Centers for Disease Control approach to rabies post-exposure prophylaxis is summerized in the algorithm below.

FIGURE 1

ALGORITHIM FOR RABIES PROPHYLAXIS


RABIES PROPHYLAXIS
1. Was person bitten or licked on an open wound or mucous membrane by a possibly rabid animal?
NO
None
YES
2. Has first aid and wound care been performed?
3. Is rabies known or suspected to be present in the species and area? (see text for details)
NO
None
YES
4. Was the animal captured?
NO
Consider RIG & Vaccine depending on type of animal & circumstances of bite.
YES
5. Was the animal a normally behaving dog or cat
YES
6. Does the animal become ill under observation during the next 10 days?
NO
None
NO
YES
7. Do the laboratory tests of the brain confirm rabies?
NO
None
YES
(8) SERUM & VACCINE

RABIES - RABIES - RABIES

FIGURE 2

RABIES POST-EXPOSURE PROPHYLAXIS GUIDE

The following recommendations are only a guide. In applying them, take into account the animal species involved, the circumstances of the bite or other exposure, the vaccination status of the animal, and presence of rabies in the region. Local or state public health officials should be consulted if questions arise about the need for rabies prophylaxis.

	Animal species	Condition of animal at time of attack	Treatment of exposed person*
DOMESTIC	dog and cat	healthy and available for 10 days of observation	none, unless animal develops rabies †
		rabid or suspected rabid	RIG‡ and HDCV §
		unknown (escaped)	consult public health officials. If treatment is indicated, give RIG‡ and HDCV §
WILD	skunk, bat, fox, coyote, raccoon, bobcat, and other carnivores	regard as rabid unless proven negative by laboratory tests ¶	RIG‡ and HDCV §
OTHER	livestock, rodents, and lagomorphs (rabbits and hares)	Consider individually. Local and state public health officials should be consulted on questions about the need for rabies prophylaxis. Bites of squirrels, hamsters, guinea pigs, gerbils, chipmunks, rats, mice, other rodents, rabbits, and hares almost never call for antirabies prophylaxis.	

* All bites and wounds should immediately be thoroughly cleansed with soap and water. If antirabies treatment is indicated, both rabies immune globulin (RIG) and human diploid cell rabies vaccine (HDCV) should be given as soon as possible, regardless of the interval from exposure.

† During the usual holding period of 10 days, begin treatment with RIG and vaccine (preferably with HDCV) at first sign of rabies in a dog or cat that has bitten someone. The symptomatic animal should be killed immediately and tested.

‡ If RIG is not available, use antirabies serum, equine (ARS). Do not use more than the recommended dosage.

§ If HDCV is not available, use duck embryo vaccine (DEV). Local reactions to vaccines are common and do not contraindicate continuing treatment. Discontinue vaccine if fluorescent-antibody (FA) tests of the animal are negative.

¶ The animal should be killed and tested as soon as possible. Holding for observation is not recommended.

FIGURE 3

RABIES PROPHYLAXIS REGIMEN

	RIG	DOSAGE	HDCV	DOSAGE	VACCINATION SCHEDULE
Pre-exposure[a]	No	----	Yes	3 - 1 ml	
Post-exposure	Yes	0.06 ml (9IV)[b] per lb. body weight	Yes	5 - 1 ml	RIG one dose on[illegible] HDCV 1 dose days 0,3,7,14,28 after first dose

[a] Pre-exposure prophylaxis should be considered for certain high-risk groups, e.g., persons who work in laboratories with rabies virus, veterinarians, persons planning to spend long period of time in countries where rabies is a constant threat, all persons whose occupation or recreational activities bring them into contact with potentially rabid an[illegible]

[b] If possible, up to half the dose of RIG should be thoroughly infiltrated into the area around the wound, and the rest administered intramuscularly.

		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING DISEASE	MUMPS	PEPTU...S	RABIES ANIMAL	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GO...
DISTRICT 1	Daniels										1					
	Phillips															1
	Roosevelt										2		1			15
	Sheridan												1			
	Valley										1					1
DISTRICT 2	Dawson										1					2
	Garfield															
	McCone										3					
	Prairie															
	Richland										2					
	Wibaux															
DISTRICT 3	Carter										1					
	Custer										1					2
	Fallon															
	Powder River															
	Rosebud			1											3	12
	Treasure															
DIST. 4	Blaine															
	Hill	1		2											1	5
	Liberty															
DISTRICT 5	Cascade												1		1	17
	Chouteau															
	Glacier															9
	Pondera												1			1
	Teton															
	Toole										4					
DISTRICT 6	Fergus										1		1			
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn							1			1					12
	Carbon														1	
	Stillwater															
	Sweet Grass															
	Yellowstone							1					3		1	27
DIST. 8	Broadwater					1										
	Jefferson												1			1
	Lewis & Clark			1												12
DIST. 9	Gallatin			1				1					2			8
	Meagher															
	Park												3			
DISTRICT 10	Flathead			1									1			3
	Lake							1	1							3
	Lincoln															
	Sanders															
DIST. 11	Mineral															
	Missoula				1			1					1		1	8
	Ravalli			1				1								
DISTRICT 12	Beaverhead			2												
	Deer Lodge															1
	Granite												1			
	Madison				1											1
	Powell			1												
	Silver Bow												1		2	2
MONTHLY TOTAL	1983	1		10	2	1		6	1		18		18		10	143
	1982			24	6	1					24	1	29	5	10	200
	1981	1		25	16	1		3	2	5	24	2	36	3	7	189
TOTAL TO DATE	1983	1		22	10	4		7	2	1	48		36	1	20	458
	1982	1		55	19	3		7	5		34	2	50	19	25	531
	1981	3		56	42	9		5	5	6	50	3	62	6	22	555

DELAYED REPORTS: Giardia--4 Gallatin; 1 Lewis & Clark; Hepatitis B--1 Lewis & Clark; Hepatitis, Unspec.--2 Yellowstone, 1 Cascade; Rabies in Animals--2 Toole, 1 Lake, 1 Judith Basin; RMSF--1 Cascade; Rubella--1 Gallatin; Salmonella--1 Rosebud, 1 Flathead

OTHER DISEASES: Colorado Tick Fever--1 Gallatin Hepatitis, Unspec.-- 2 Gallatin, 1 Missoula; Tularemia-- 1 Custer; Legionella--1 Fergus; Psittacosis--1 Silver Bow

MMWR NOW AVAILABLE AT REASONABLE COST[1]

On October 1, 1982, the Centers for Disease Control stopped free distribution of its Morbidity and Mortality Weekly Report (MMWR). A paid subscription system through the National Technical Information Service was started at that time. The annual subscription rate is now $70 for third class mail delivery and $90 for first class mail.

This very high cost has discouraged many Montana physicians, health department staff members, and other health care providers from continuing their subscriptions. Because we consider the MMWR an excellent source of timely information about important public health problems, we explored possible ways to provide it to interested Montana health care providers at a more reasonable cost.

Before local arrangements could be made, we learned of two national sources of the reasonably priced MMWR subscriptions. We present essential information about each source here. The following factors should be considered in using this information:

1. First class mail takes approximately three to four days to go from the east coast to west coast; third class takes approximately twelve days.[2]

2. Persons who have purchased subscriptions to the MMWR through the National Technical Information Service may cancel those subscriptions; a refund for the unused portion of the subscription will be made.[3] Such cancellation should be addressed to:

   National Technical Information Service
   5285 Port Royal Road
   Springfield, VA 22161

3. The MMWR supplements often provide comprehensive statements about important public health topics.

4. Copying and distribution of the MMWR by any party is legal, for federal publications are not protected by copyright laws.

5. Subscription requests to either source should include full name and mailing address AND prepayment of the subscription fee.

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2. U.S. Post Service, (personal communication), March 4, 1983.
3. Mrs. Frances Stamm, Subscription Department, National Technical Information Services, (personal communication), March 3, 1983 (telephone number 707-487-4600).
4. Advertisement, New Eng. J. Med., February 10, 1983, and Dr. Victor Alexander (personal communication), March 23, 1983.
5. Advertisement, New Eng. J. Med., February 24, 1983.

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Volume: 7:4 **Month of:** March, 1983

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		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels														1	
	Phillips															
	Roosevelt															3
	Sheridan															
	Valley										6					3
DISTRICT 2	Dawson										1					1
	Garfield															
	McCone															
	Prairie															
	Richland										1					
	Wibaux															
DISTRICT 3	Carter															
	Custer															2
	Fallon															
	Powder River															
	Rosebud														1	4
	Treasure															1
DIST. 4	Blaine															
	Hill			1												3
	Liberty															
DISTRICT 5	Cascade															22
	Chouteau															
	Glacier															11
	Pondera															
	Teton															
	Toole										1					
DISTRICT 6	Fergus															
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn										1					3
	Carbon															
	Stillwater				1											
	Sweet Grass															
	Yellowstone				2	2			1				1			24
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			1												12
DIST. 9	Gallatin			6									1			8
	Meagher															
	Park															
DISTRICT 10	Flathead														1	2
	Lake															4
	Lincoln															
	Sanders												1			
DIST. 11	Mineral															
	Missoula				1									1	2	5
	Ravalli							1								
DISTRICT 12	Beaverhead												1			
	Deer Lodge															1
	Granite															
	Madison															
	Powell															
	Silver Bow												1			3
MONTHLY TOTAL	1983	-	-	8	4	2	-	1	1	-	10	-	5	1	5	112
	1982	-	-	10	5	1	-	1	2	-	3	1	4	1	5	115
	1981	-	-	10	14	-	-	1	-	-	3	-	5	2	5	80
TOTAL TO DATE	1983	-	-	12	8	3	-	1	1	1	30	-	18	1	10	315
	1982	1	-	31	13	2	-	6	3	-	10	1	21	14	15	331
	1981	1	-	31	26	8	-	2	3	-	26	1	25	3	17	353

DELAYED REPORTS: Giardia--1, Beaverhead; 1, Missoula; 3, Gallatin. Rabies In Animals--1, Dawson. Salmonella--1, Toole; 2, Gallatin; 3, Missoula; 1, Yellowstone.

OTHER DISEASES: Bacterial Meningitis--1, Missoula; 1, Yellowstone. Colorado Tick Fever--1, Missoula.

SHOULD HEALTH CARE PERSONNEL WHO ARE HEPATITIS B SURFACE ANTIGEN-POSITIVE BE RESTRICTED FROM PATIENT CONTACT?

The occurrence of hepatitis B in health care personnel continues to be of concern to health care institutions as well as practitioners. It is estimated that as many as 3% of personnel in certain high-risk health care services (e.g., emergency medical service, pathology, or surgery) may be hepatitis B surface antigen (HBsAg)-positive at any given time; 0.6% of all health care workers are known to be chronic HBsAg carriers.

Hepatitis B vaccine became available from Merck, Sharp and Dohme in the fall of 1982, and many hospitals have initiated prevaccination screening programs to determine who should receive the vaccine. While protocols vary, testing for previously acquired immunity to hepatitis B (anti-HBs) is considered preferable to testing for HBsAg which identifies only acute and chronic hepatitis B cases and fails to identify individuals who have acquired immune status. Also, difficult questions arise regarding the need for work restrictions for the health care worker who is not acutely ill but is HBsAg-positive. The Centers for Disease Control recommend that health care personnel not be restricted from patient contact solely on the basis of this serologic finding, but rather, that these and other personnel be educated as to the potential mechanisms of transmission and that efforts be made to minimize potential risks.

Although HBsAg-positive employees are potentially contagious, hepatitis B has been transmitted to their patient contacts in only a few exceptional cases in which a combination of factors facilitated transmission: 1) the carrier was positive for hepatitis B e antigen (HBeAg), a serologic marker associated with active viral replication; 2) there was a high degree of trauma to the patient and/or invasive therapy which provided a portal of entry for the virus; and 3) the patient had either percutaneous or mucous membrane contact with infectious serous fluids from the carrier (such as from dermatologic lesions or trauma). In the absence of these circumstances, transmission of hepatitis B is unlikely even if the health care provider is positive for both HBsAg and HBeAg.

It is extremely important to prevent misunderstandings between employers and employees concerning the professional management of HBsAg-positive health care workers. Each HBsAg-positive employee should be retested at least annually to determine if antigenemia persists. Unless HBsAg-positive individuals clearly have been associated with hepatitis B transmission, they need not be restricted from patient care, laboratory, or surgical activities. However, they should be advised to observe blood precautions and to use additional preventive measures (such as double gloving) when necessary. An employee's return to work after the acute phase of hepatitis B infection is usually decided by the employee's attending physician and should not depend solely on the employee's HBsAg status.

CHILDHOOD IMMUNIZATIONS--FUTURE SUPPLY OF VACCINE

Vaccine for immunizing Montana children will continue to be supplied to all public and private providers upon request from the Childhood Immunization Program. There will be a change in our policy concerning what vaccine we will provide, though. Due to the very limited amounts of single antigen vaccines such as Measles, Rubella, Mumps, and the combination Measles-Rubella (M-R) being ordered, we will only be supplying the combination Measles-Mumps-Rubella (MMR) as of April 1, 1983. This decision is predicated on two factors:

(1) The Program has a 500 dose minimum ordering requirement for the live virus vaccines. Because very few doses have been used over the last year, considerable amounts have out-dated and have had to be destroyed. Also, no credit can be givin on these out-dated vaccines.
(2) Studies have indicated that no deleterious effects appear when children receive a vaccine when they have already been immunized or had the disease. Consequently, MMR vaccine could be given to a child when the child has previously been immunized with one or two of the single antigen vaccines.

All other vaccines, DTP, Td, and Polio (single dose), will be supplied as always. If you have questions, please call The Immunization Program, 449-4740.

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		ASEPTIC MENINGITIS	ENCEPHALITIS	GIARDIA	HEPATITIS A	HEPATITIS B	MEASLES	MENING. DISEASE	MUMPS	PERTUSSIS	RABIES, ANIMALS	RUBELLA	SALMONELLA	SHIGELLA	TUBERCULOSIS	GONORRHEA
DISTRICT 1	Daniels															
	Phillips										1					
	Roosevelt										1					15
	Sheridan															
	Valley															2
DISTRICT 2	Dawson										1					1
	Garfield															
	McCone															
	Prairie										1					
	Richland				1	1										
	Wibaux															
DISTRICT 3	Carter															
	Custer															3
	Fallon															
	Powder River															
	Rosebud															8
	Treasure															
DIST. 4	Blaine															2
	Hill															3
	Liberty															
DISTRICT 5	Cascade															9
	Chouteau															
	Glacier															7
	Pondera															
	Teton															
	Toole										2					
DISTRICT 6	Fergus															1
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn															14
	Carbon															
	Stillwater				1											1
	Sweet Grass															
	Yellowstone				1								2		1	27
DIST. 8	Broadwater															
	Jefferson															
	Lewis & Clark			1									1			6
DIST. 9	Gallatin												1			
	Meagher															
	Park															
DISTRICT 10	Flathead															1
	Lake															
	Lincoln															
	Sanders															
DIST. 11	Mineral															
	Missoula												1		1	7
	Ravalli															1
DISTRICT 12	Beaverhead															1
	Deer Lodge															3
	Granite															
	Madison															
	Powell															1
	Silver Bow															2
MONTHLY TOTAL	1983	-	-	1	3	1	-	-	-	-	6	-	5	-	2	115
	1982	-	-	5	3	-	-	-	-	-	5	-	2	9	9	104
	1981	-	-	11	4	4	-	-	3	-	13	1	6	-	6	124
TOTAL TO DATE	1983	-	-	4	4	1	-	-	-	1	20	-	13	-	5	203
	1982	-	-	8	4	-	-	3	1	-	7	-	6	13	9	216
	1981	1	-	21	13	7	-	1	-	3	23	1	20	-	12	257

DELAYED REPORTS: Giardia--3, Missoula. Hepatitis A--1, Cascade. Hepatitis B--1, Lewis & Clark; 1, Yellowstone. Rabies in Animals--1, Toole; 1, Musselshell. Rubella--1, Beaverhead. Salmonella--1, Ravalli; 1, Park.

OTHER DISEASES: Bacterial Meningitis--1, Missoula; 1, Hill. Legionella--1, Custer (deceased).

ACQUIRED IMMUNE DEFICIENCY SYNDROME

Over the past few years, the medical community's perception of Kaposi's sarcoma (KS) has changed dramatically. KS used to be a rare malignant neoplasm found most often in elderly men of Mediterranean or Jewish ancestry and young men from equatorial Africa. Next came the association of a very aggressive form of KS with male homosexuals. Now KS is only one of a diverse array of problems listed under the general term of acquired immune deficiency syndrome (AIDS). The Centers for Disease Control (CDC) defines a case of AIDS as a disease, at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease, i.e., with no history of immunosuppressive therapy or underlying illness. Such diseases include KS, Pneumocystis carinii pneumonia, and other serious opportunistic infections.

The association with homosexuality is well-estahlished. As of September 15, 1982, CDC had received reports of nearly 600 cases of AIDS. Seventy-five percent of these were in homosexual or bisexual males. Intravenous drug abuse is also associated with AIDS. Sixty percent of the heterosexuals, and twelve percent of homo- and bisexual patients with AIDS report intravenous drug use. In addition, as of July 3, 1982, AIDS has been diagnosed in 36 Haitians, the majority of whom reside in Miami or Brooklyn, New York, and in 3 hemophiliacs.

The incidence of AIDS in the United States has roughly doubled every half year since the second half of 1979. An average of 1 to 2 cases are diagnosed every day. The overall case fatality rate for the 593 cases diagnosed as of September 15, 1982, was 41 percent. However, for cases that have been diagnosed for over a year, this rate exceeds 60 percent.

Almost 80 percent of the cases reported in the U.S. have been concentrated in six metropolitan areas: New York City, San Francisco, Miami, Newark, Houston, and Los Angeles. This is not merely a reflection of the population size in these areas. The number of cases per million population in New York City and San Francisco is approximately ten times greater than in the entire country.

Many theories have been proposed to explain the occurrence of AIDS. Most researchers agree that the causal agent or agents produce a selective T-cell defect which leaves the person vulnerable to opportunistic infections or malignancies. The agents under suspicion include viruses, such as: the cytomegalovirus, Epstein-Barr virus, herpes simplex type 2, and hepatitis viruses. Several researchers have hypothesized a previously unknown or new strain of virus. Chemical agents such as marijuana and amyl and isobutyl nitrates, sperm entering the blood stream, and genetic predisposition are also being explored.

Because a transmissible agent may be involved, the CDC currently recommends that those caring for AIDS patients use precautions in handling blood and body fluids, as with hepatitis B patients. Many therapeutic modalities are being tried, including, immune potentiators (such as synthetic interferon), antineoplastic agents and various antibiotics. One thing that all AIDS cases have in common is that they are very difficult to treat.

In summary, AIDS is a serious condition for which there is no specific diagnostic test, the etiologic agent or agents are unknown, and there is no satisfactory treatment. The incidence of the disease is increasing at an alarming rate and the case fatality rate is high. The high-risk groups identified to date are the "4-H's": homosexuals, hemophiliacs, Haitians, and heroine abusers. When more is known about the full spectrum of AIDS, from asymptomatic cases to those with non-specific symptoms, a more diverse population at risk may be identified.

No cases of AIDS have been reported to date in Montana. The Division of Health Services and Medical Facilities would appreciate reports of any possible or confirmed AIDS cases in Montana.

GENERAL RECOMMENDATIONS ON IMMUNIZATION

The first issue of MMWR for 1983 (January 14) contains the most current recommendations on immunization from the Advisory Committee on Immunization Practices. This revision updates the 1980 statement. Changes from that statement clarify information on possible interference with the immune response by spacing immunobiologics. Recommendations for vaccinating persons with allergies are revised. New sections dealing with many aspects of immunization procedures have been added. Anyone who would like to receive the text of these recommendations please contact the Childhood Immunization Program, Cogswell Building, Helena, Montana, 59620 (449-4740).

NEW OFFICIAL IMMUNIZATION RECORD CARD

The large, black "Official Record Card" has recently been redesigned. The new card is wallet size and made of a virtually indestructable fiber paper. In the past, the record card was used primarily for mothers of newborn children. But in retrospect, the purpose of a standard record card should be for all children in Montana. The Immunization program will be distributing these new record cards through appropriate local public health personnel to all facilities, public and private, providing immunizations throughout the entire state. If anyone should want a supply of these record cards, contact your local health department or Immunization Program, Cogswell Building, Helena, MT 59620 (449-4740).

INFLUENZA IN MONTANA AND THE UNITED STATES

As of the end of January, the State Laboratory has isolated influenza virus from 42 individuals and has serologically confirmed 36 people. Every one of these cases are of the Influenza A (H3N2) variety. This strain of Influenza A is like the Bangkok/1/79 virus. The specimens from these cases have been received from 16 counties, primarily from the western part of the state. Unconfirmed reports have been received from many other counties that say flu-like illness is currently present in their counties. This appears to be a banner year for flu compared to the past few years. No Influenza B has been isolated to date.

Influenza type A(H3N2) virus has now been isolated from patients in 24 states. Nine of these(Florida, Idaho, Kansas, Louisiana, Maine, Missouri, Nevada, Oklahoma, and South Dakota) have reported their first isolates of the season from patients with onset from late December 1982 through mid-January 1983. The first influenza type B isolate from the United States this season was obtained from a 42-year old male in Houston, Texas, who developed influenza on December 20. The first influenza type A(H1N1) isolates were obtained from two Chicago residents. The first, a 10-year-old male, had onset of illness on December 27, 1982, and was hospitalized with severe asthma on December 29. He recovered and was discharged on January 8. The other, a 26-year-old female, had typical influenza-like illness. Most of the influenza isolations mentioned above (except those in Idaho and South Dakota) have been associated with sporadic activity.

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DISTRICT 1	Daniels															
	Phillips										1					
	Roosevelt									1						2
	Sheridan															
	Valley										2					
DISTRICT 2	Dawson															1
	Garfield															
	McCone										2					
	Prairie										1					
	Richland															2
	Wibaux															
DISTRICT 3	Carter															
	Custer															1
	Fallon															
	Powder River															
	Rosebud														1	2
	Treasure															
DIST. 4	Blaine															2
	Hill															4
	Liberty															
DISTRICT 5	Cascade				1						1		2			5
	Chouteau															
	Glacier														1	3
	Pondera															
	Teton															
	Toole										7					
DISTRICT 6	Fergus															
	Golden Valley															
	Judith Basin															
	Musselshell															
	Petroleum															
	Wheatland															
DISTRICT 7	Big Horn															6
	Carbon															
	Stillwater															
	Sweet Grass															
	Yellowstone												1		1	22
DIST. 8	Broadwater															1
	Jefferson															
	Lewis & Clark			1									1			7
DIST. 9	Gallatin			2												2
	Meagher															
	Park												2			1
DISTRICT 10	Flathead															
	Lake															2
	Lincoln															
	Sanders															
DIST. 11	Mineral															
	Missoula												1		2	12
	Ravalli															1
DISTRICT 12	Beaverhead															8
	Deer Lodge															2
	Granite															
	Madison															1
	Powell															
	Silver Bow												1			1
MONTHLY TOTAL	1983	-	-	3	1	-	-	-	-	1	14	-	8	-	[illegible]	[illegible]
	1982	-	-	3	1	-	-	3	1	-	2	-	4	4	-	[illegible]
	1981	1	-	6	5	3	-	1	-	-	5	-	11	-	6	90
TOTAL TO DATE	19															
	19															
	19															

DELAYED REPORTS: Giardia--1, Flathead. Hepatitis A--1, Sanders; 3, Yellowstone. Hepatitis B--1, Musselshell, 1, Missoula. Rabies in Animals--2, Valley; 1, Daniels; 1, Fergus. Salmonella--1, Lincoln; 1, Glacier. Shigella--1, Blaine; 1, Silver Bow.

OTHER DISEASES: Bacterial Meningitis--1, Silver Bow. Legionella--1, Cascade. Syphilis, Early Latent<1 yr.--1, Cascade.